MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2004

Empire Fire and Marine Insurance Company
13810 FNB Parkway
Omaha, NE 68154-5202

NAIC Group Code 0212
NAIC Company Code 21326

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS
FOR
COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

Empire Fire and Marine Insurance Company
13810 FNB Parkway
Omaha, NE 68154-5202

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Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

November 22, 2005

The Honorable David F. Rivera
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Empire Fire and Marine Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205, 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health insurers. We examined the Company's records at its office located at 2101 W. Peoria Ave, Suite 100, Phoenix, AZ 85029-4925. The market conduct examination covered the period from January 1, 2004 through December 31, 2004.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT EXAMINATION REPORT OF EMPIRE FIRE AND MARINE INSURANCE COMPANY

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COMPANY PROFILE

The Company provided the following profile of its business and operations:

The Company is a member of a group of U.S. based property and casualty insurers which provide a variety of commercial insurance and risk management products and services to domestic and international companies. Zurich American Insurance Company is the Company's ultimate parent and is a lead company in the group, which is 100% owned by Zurich Holding Company of America, Inc., which is in turn 99.87% owned by Zurich Insurance Company, Zurich, Switzerland. Zurich Insurance Company is 100% owned by Zurich Group Holding, Switzerland, which in turn is 100% owned directly and indirectly by Zurich Financial Services, Switzerland. All the member companies, directly or indirectly participate in an intercompany pooling agreement. Under the terms of the Pooling Agreement, all transactions included in the net income or loss resulting from underwriting operations and the related asset and liability accounts are distributed net of other reinsurance, 100% to Zurich American Insurance Company.

The Company was licensed and began operation in Colorado on June 13, 1963. It is licensed as an admitted carrier in all states, except Oklahoma, where it is licensed as a surplus lines carrier. The Company's dealer division supports two programs, the independent and the auto dealer and recreational vehicle dealer. The products available include garage liability coverage, dealer's errors and omissions, physical damage coverage for the dealer's owned inventory, garagekeepers liability, crime, inland marine, and property. These products are sold through employee agents for Colorado. The Company's programs division's target markets consist of commercial auto related classes of business, such as trucking, tow trucks, petroleum haulers and ambulances that are written through general agents. The Company also offers an individual major medical product and crop hail insurance.

Effective February 12th, 2001 American Select Insurance Management Corporation began DOI filings on behalf of Empire Fire and Marine Insurance Company. Marketing of the Empire plans commenced on September 1, 2001. American Select Insurance Management Corporation ("ASIMC") was founded in 1999 by James O. Bowles, who is currently the President and CEO. The primary role of American Select Insurance Management Corporation is to provide a turnkey approach for carriers who want to be in the individual health market or who already are and wish to improve their risk management and marketing position. The company operates in a Program Management role with other expert strategic partner alliances in reinsurance, actuarial management, administration and marketing to fulfill the objectives desired of the carrier.

The principal tenets of the company are as follows:

- Strong risk management guidance
- Building of a strong distribution
- Alignment with high quality strategic partners
- Development of innovative products

In order to fulfill these objectives, American Select Insurance Management Corporation creates strategic alliances to support the health insurance programs. The current strategic alliance partner relationships in place for the Empire Fire and Marine Insurance Company ("Empire") program are:

- Insurers Administrative Corporation (IAC) – Third Party Administration
- American Re – Reinsurer
- Actuarial Management Corporation (AMC) – Actuarial
- Milliman USA – Actuarial

Currently the Empire plans are marketed in 20 states using two distinct marketing organizations. They are American Select Insurance Marketing Corporation a separate organization from American Select Insurance Management Corporation and America's Health Choice Plan.

ASIMC, as the Program Manager, manages the Empire program through monitoring of key indicators on a daily, weekly and monthly basis with comprehensive and detailed reporting at quarterly strategic alliance meetings with all partners of the program including key members of Empire. All areas of the program are monitored for trends and evaluated with the executive team for any variances. Corrective actions are developed and implemented as needed. Any significant variances to the program in terms of underwriting, claims or rate strategy are reviewed and authorized by the strategic alliance partners.

The key indicators that are reviewed at the quarterly strategic alliance meetings include: forms compliance, agent contracting/appointment activity and process, agent training, underwriting (risk assessment), high risk management, rescission, reformation, policy issue, claims, policy administration, renewal rate action, in force business complaint activity and claims trends.

The Compliance Officer of ASIMC is responsible for policy, form and application filings as well as changes to existing filings and maintaining the program in compliance with all DOI statutes.

The Risk Assessment Officer of ASIMC is responsible to create underwriting guidelines and review practices with "IAC". In addition, the Risk Assessment Officer is involved in all potential rescissions and reformations by participating in committees that oversee these actions and providing final approval on all proposed actions. Underwriting audits are conducted usually in conjunction with the timing of an American Re audit.

The Claims Officer of ASIMC is responsible for the overall coordination with the Risk Assessment Officer on rescissions and reformations and participates in the same committee reviews. In addition, the Claims Officer will conduct claims audits quarterly to ensure that all practices, procedures and DOI requirements are met by IAC. This is sometimes performed in conjunction with a quarterly audit conducted by American Re.

The Chief Operations Officer of ASIMC is responsible for coordinating global activity at ASIMC as it relates to the Program Management and is responsible for the actions performed by IAC and communicating changes to them in procedures or processes. This includes any new product or plan releases on behalf of a Carrier relationship through Administrative Bulletins requiring review and signoff by IAC regarding the action to be taken. The Administrative Bulletins form the basis for audits and training manuals at IAC.

The Chief Distribution Officer is responsible for sales of the plans in the 20 states where the Empire plan is available with direct contact with all marketing distributions and recruiting efforts. In tandem the Marketing Communication and Product Officers handle all notices to the Distribution that are marketing related and are responsible for all brochures, rates and sales materials released and conduct agent training and quality review of all web site sales materials.

The Agency Marketing Officer manages the operations staff in the Lakewood Office inclusive of licensing and contracting, TPA operations and Technology staff as well being the key liaison with Empire contracted Agents and Distribution Management.

Overall the officers and managers of ASIMC are focused on the distribution, marketing, management and overall performance of the Empire block as their core responsibilities.

ASIMC operates its own internet web site used by the sales distribution and internal officers to review activity, reports, pending information and general management reports. In addition, satellite offices have access through a VPN connection to the main database in Colorado for reports. The Risk Assessment Officer and Claims Officer also have access to the IAC Onbase system for review of files for claims.

ASIMC produced through their various distribution channels a total of $48,227,514 of new written premium in 2004 with $9,809,583 specific to sales in the state of Colorado. Empire paid claims for 2004 were $33,476,240 with $7,189,191 paid to Colorado customers who purchased Empire products.

The Company's 2004 direct written premium for accident and health plans in Colorado was $9,810,000, which represents 1.32% of the market share.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Empire Fire and Marine Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws and with generally accepted operating principles related to individual sickness and accident insurance. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2004 through December 31, 2004.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

For the period under examination, the examiners included statutory citations and regulatory references related to individual insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-7-109	Suicide no defense for nonpayment
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-123	Telemedicine
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Section 10-20-119	Prohibited advertisement of association article in insurance sales – notice to policyholders
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Repealed and Repromulgated Regulation 1-1-7	Market Conduct Record Retention
Repromulgated Regulation 4-2-1	Replacement Of Accident And Sickness Insurance
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Amended Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance

Regulation 4-2-15	Required Provisions in Carrier Contracts With Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Amended Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations
Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Applications, Endorsements and Rider Forms:

FORM NUMBER	FORM NAME
EM 28 18 (04-01)-P-CO	Individual Preferred Provider Major Medical Policy
EM 28 19 (08-03)-APP-CO/GA	Major Medical Insurance Application
EM 28 21 (04-01)-SAB	Supplemental Accident Benefit Rider
EM 28 78 (10-03)-OCC	24-Hour Occupational Coverage Benefit Rider
EM 28 76 (10-03)-RID-CO	Amendment Rider
CO NOTICES 12/04	Replacement Notice
GAN-CO-1201 (Empire)	Summary of the Life and Health Insurance Protection Association Act and Notice Concerning Coverage Limitations and Exclusions

EM 28 53 (01-02)-SEBG-CO	Determination of Self-Employed Business Group of One
No Form Number	Colorado Standard Health Plan Description Form

The most frequently sold plan in Colorado in 2004 was the HV+ [Heritage], an individual Major Medical Expense Plan, Form Number EM 28 18.

Rating

The examiners reviewed a randomly selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

For cases that were initially effective or renewed during the period from January 1, 2004 through December 31, 2004, the examiners used ACL ™ software to randomly select fifty (50) individual new business application files and fifty (50) individual renewal business files. The Company furnished a population of 764 new business files and 2,720 renewal business files. These files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations/Rescissions

For individual cases that were declined during 2004, the Company provided data reflecting 164 files and for cases that were rescinded in 2004, the Company provided data reflecting 138 files. The examiners used ACL ™ software to randomly select fifty (50) declined files and fifty (50) rescinded files to be reviewed.

Claims

The examiners used ACL ™ software to randomly select samples of electronically received and non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL ™ software to randomly select samples of 100 Paid claims and 100 Denied claims that were reviewed for the Company's overall claims handling practices.

Utilization Review

Empire Fire and Marine Insurance Company does not perform utilization review for Colorado insureds; does not require that Colorado insureds obtain pre-authorization or pre-certification for services, procedures or in-patient admissions; or perform concurrent review of in-patient admissions. Empire terminated all utilization review and does not deny or limit any services based on the notification nor does the Company deny or limit benefits based on the absence of such notification. The Company requests that insureds notify the company of any hospitalization, skilled nursing facility confinement,

emergency or maternity admissions, home health care/hospice services, surgical or diagnostic procedures. A telephone notification log is created of such notifications. The Company does not perform utilization review and does not deny or limit any services based on the notification nor does the Company deny or limit benefits based on the absence of such notification.

When a hospital, other facility or provider calls to provide notification, the provider is told that the insurer does not require or offer pre-authorization or pre-certification in Colorado. The hospital, other facility or provider is also told that notification is not a guarantee of coverage and that final claim determination is made following receipt and review of the actual claim.

The telephone notification log is used to identify as early as possible (a) appropriate candidates for large case management; (b) potential large claims losses to set reserves; and (c) potential large claim losses for reinsurer notification.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twelve (12) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found one (1) area of concern in their review of company operations and management. The following issues were identified:

    - Certifying and using forms that do not comply with Colorado insurance law.

  It is recommended that the Company develop, implement, and monitor the necessary procedures to ensure that all forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company.

- **Policy Forms:** The examiners found seven (7) areas of concern in their review of the most frequently sold individual coverage forms in use during the year under examination. The following issues were identified:

    - Failure to provide benefits for covered services based on a licensed provider's status, e.g., an immediate family member, residing in the home of the insured person or being the employer of an insured's immediate family member.

    - Failure to reflect wording that would allow coverage for intentional self-inflicted injury, suicide or attempted suicide while insane.

    - Failure to reflect correctly and completely the extent of coverage to be provided for hospice and home health care services.

    - Failure to reflect correct information as to when adopted children become dependents eligible for coverage.

    - Failure to reflect that repairs of prosthetic devices, unless due to misuse or loss, are to be covered.

    - Failure to reflect the availability of an independent external review in grievance procedures.

    - Failure to use the correct Standard Health Benefit Plan Description Form during 2004.

  It is recommended that the Company review and revise all applicable policy forms to ensure compliance with the requirements of Colorado insurance law.

- **Rating:** The examiners found no areas of concern in their review of the rates and associated required rate filings.

- **Applications:** The examiners found no areas of concern in their review of application files for the examination period.

- **Cancellations/Non-Renewals/Declinations:** The examiners found one (1) area of concern in their review of cancellations/non-renewals/declinations/rescissions.

    - Failure to provide CoverColorado notice forms in all required instances.

  It is recommended that the Company establish procedures to ensure that CoverColorado notice forms are provided in all instances required by Colorado insurance law.

- **Claims:** The examiners found three (3) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

    - Failure, in some cases, to pay, deny or settle claims within the required time periods.

    - Failure to accurately determine the number of days used for claim processing.

    - Failure, in some cases, to pay late payment interest/penalties on claims.

  It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time periods required by Colorado insurance law. Procedures should also be established to ensure that the number of days utilized for claim processing is calculated correctly and that late payment interest and penalties are paid in all applicable instances.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

EMPIRE FIRE AND MARINE INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(1)(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company in 2004 were in compliance with statutory mandates.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. American Select Insurance Management Corporation operates in a Program Management role and effective February 12, 2001 began Division of Insurance filings on behalf of Empire Fire and Marine Insurance Company. Empire's policy forms were reviewed by American Select in order to locate any inconsistencies with Colorado insurance law that needed to be addressed with Insurers Administrative Corporation that acts as a TPA for Empire. American Select issued Administrative Bulletin #2005-25 on August 5, 2005 until such time as a Policy Amendment Rider could be prepared for filing in Colorado. This Administrative Bulletin corrected some of the issues raised by this examination, but the forms used during 2004, the period under examination, were not in compliance with Colorado insurance law as they were certified to be.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to provide benefits for covered services based on a licensed provider's status, e.g., an immediate family member, residing in the home of the insured person or being the employer of an insured's immediate family member.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers

(a) Sickness and accident insurance.

(I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

The Company's most frequently sold policy in Colorado in 2004 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, e.g., an immediate family member, residing in the home of the covered person, or being the employer of an immediate family member.

The wording on page 14 of the policy is:

SECTION I

DEFINITIONS

Participating Provider

A *provider* who is not an *immediate family member* and who has agreed to participate in your selected *preferred provider network.*

Physician

A person who is not an *immediate family member*, but is one of the following:

- a Doctor of Medicine or a Doctor of Osteopathy;
- a Doctor of Podiatry or a Doctor of Chiropractic; or,
- any other licensed health care practitioner who is required to be recognized as a *physician* by state law and acts within the scope of his/her license to treat an *illness* or *injury*.

The wording on page 33 of the policy is:

SECTION IV

Exclusions

The following exclusions are applicable to all Health Insurance Benefits.

48. Services and/or supplies furnished and/or provided by an *immediate family member* or a person who ordinarily resides in the home of the *covered person* or by the employer of an *immediate family member*, except for *covered expenses* rendered while *hospital confined*.

Form Number	Form Name
EM 28 18 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage HV+ [Heritage]

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. American Select Insurance Management Corporation operates in a Program Management role and effective February 12, 2001 began Division of Insurance filings on behalf of Empire Fire and Marine Insurance Company. Empire's policy forms were reviewed by American Select in order to locate any inconsistencies with Colorado insurance law that needed to be addressed with Insurers Administrative Corporation (IAC) that acts as a TPA for Empire. American Select issued Administrative Bulletin #2005-25 on August 5, 2005 and instructed IAC to comply administratively until such time as a Policy Amendment Rider could be prepared for filing in Colorado. This Administrative Bulletin # 2005 does reflect that the "immediate family member" exclusion: does not apply to the insured's family member solely on the provider's family member status if the provider is acting within the scope of his/her license and the provider normally charges for the services. However during 2004, the period under examination, the exclusion was in effect.

Issue E2: Failure to reflect wording that would allow coverage for intentional self-inflicted injury, suicide or attempted suicide while insane.

Section 10-16-102, C.R.S., Definitions, states:

> (30) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both.

Bulletin 8-99, issued October 22, 1999 states:

> Suicide Exclusions And Exclusions For
>
> Intentionally Self-Inflicted Injuries In Health Insurance Policies
>
> Section 1: Background and Purpose
>
> The Division of Insurance ("Division") has received consumer complaints concerning some health insurance carriers' usage and interpretations of suicide exclusions and exclusions for intentionally self-inflicted injuries in their policies. Some carriers are using exclusions to deny coverage for intentionally self-inflicted injuries, including suicide or attempted suicide, even where the injury, suicide or suicide attempt may be the result of sickness, accident or illness, which is covered under the policy. The exclusions at issue use language the same or substantially similar to the following: "benefits are excluded for treatment as a result of attempted suicide or suicide or intentionally self-inflicted injury, whether sane or insane." The purpose for this bulletin is to clarify the Division's position on this issue.
>
> Section 2: Applicability and Scope
>
> The subject matter of this bulletin concerns all health insurance carriers that use exclusions for intentionally self-inflicted injuries, including suicide and suicide attempts in their policies.
>
> Section 3: Division Position
>
> The Division adheres to the opinion of the Colorado courts that suicide, attempted suicide or other acts of self-destruction committed while insane are an accident. Those performing the above acts while insane are incapable of formulating the intent necessary to categorize the act as intentional. Therefore, insurance policies that provide coverage for sickness, accidents and illness, either as may be required by law (such as for mental illness) or otherwise, may not deny coverage for intentional acts committed while insane. Such exclusions are contrary to law and are void as against public policy. Accordingly, carriers are advised to amend policy language and interpret existing policy language accordingly.

> The prevailing view in Colorado courts is that broad exclusions for self-inflicted injuries or suicide attempts may not be applied in instances in which the insured or member was "insane" at the time of injury in sickness and accident policies written in Colorado. See e.g., Continental Casualty Co. v. Maguire, 471 P.2d 636 (Colo. Ct. App. 1970); Metropolitan Life Insur. Co. v. Wright, 480 P.2d 597 (Colo. Ct. App. 1971); Mass. Protective Ass'n v. Daugherty, 288 P. 888(Colo. 1930) (life insurance policy). The reasoning applied by these courts is that injuries sustained in such circumstances are "accidents," not "intentional" acts, since an individual who is insane is incapable of forming the requisite intent.

The Company's most frequently sold policy in Colorado in 2004, reflects an exclusion from paying expenses resulting from intentional self-inflicted injury, suicide or attempted suicide that does not appear to be in compliance with Colorado insurance law which adheres to the opinion of the Colorado courts that suicide or other acts of self-destruction committed while insane are an accident.

The wording on page 31 of the policy is:

SECTION IV

Exclusions

The following exclusions are applicable to all Health Insurance Benefits.

27. Expenses resulting from intentional self-inflicted injury, suicide or attempted suicide, whether sane or insane.

Form Number	Form Name
EM 28 18 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage HV+ [Heritage]

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. American Select Insurance Management Corporation operates in a Program Management role and effective February 12, 2001 began Division of Insurance filings on behalf of Empire Fire and Marine Insurance Company. Empire's policy forms were reviewed by American Select in order to locate any inconsistencies with Colorado insurance law that needed to be addressed with Insurers Administrative Corporation (IAC) that acts as a TPA for Empire. American Select issued Administrative Bulletin #2005-25 on August 5, 2005 and instructed IAC to comply administratively until such time as a Policy Amendment Rider could be prepared for filing in Colorado. This Administrative Bulletin # 2005 does clarify that the suicide exclusion does not apply to intentional acts committed while insane, however during 2004, the period under examination, the exclusion was in effect.

Issue E3: Failure to reflect correctly and completely the extent of coverage to be provided for hospice and home health care services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

(B)(II) The provisions of subparagraph (I) of this paragraph (a) shall apply:

(A) To all individual sickness and accident policies issued on and after July 1, 1973.

(8) Availability of hospice care coverage.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state *clearly and completely the criteria for and extent of coverage for home health services and hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 4. Requirements for Home Health Services

A. Definitions.

(4) "*Medical social services*" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition. [Emphasis added.]

C. Benefits for Home Health Care Services.

(3) The policy offered shall include benefits for the following services:

(e) Speech therapy and *audiology*;

(f) Respiratory and *inhalation* therapy;

(h) *Medical social services;* [Emphases added.]

Section 5. Requirements for Hospice Care

A. Definitions.

(4) *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties*. [Emphasis added.]

(12) *"Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(15) "Hospice levels of care"

(c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program

and under its care, without regard to which, if any, services are actually provided on a specific day.

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day* for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

(3) *The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*: [Emphasis added.]

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

The Company's most frequently sold policy in Colorado in 2004 does not appear to reflect correctly and completely the extent of coverage to be provided for hospice care services in the following ways:

One: The explanation of who may receive bereavement support services appears to be more limiting than allowed by Colorado insurance law. A patient/family is to be one unit of care consisting not only of the immediate family, but also the primary care giver and individuals with significant personal ties.

Two Nothing is reflected in the policy concerning the fact that "Home care services" are hospice services, to be provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

Three: Nothing is reflected in the policy concerning the "Inpatient hospice respite care" level of care to be provided on an intermittent, non-routine, short-term basis to provide the caregiver a period of relief.

Four: Nothing is reflected in the policy to indicate that there are twelve (12) benefits which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

Five: The following five (5) hospice care services required to be provided, are not reflected in the list of covered expenses for hospice care in the policy: Oxygen and respiratory supplies, Diagnostic testing, Rental or purchase of durable equipment, Transportation and Physicians services.

The Home Health Care Benefits reflected in the most frequently sold policy in Colorado in 2004 do not completely describe the mandated home health benefits in the following ways:

- Medical Social Services are not included in the description of covered services as is required by Colorado insurance law. In addition, the information provided under "Other Covered Expenses for Home health care" indicates that such services are specifically excluded from coverage under the plan.

- There is nothing reflected concerning the fact that inhalation therapy and audiology are home health services to be provided.

The wording on page 11 of the policy is:

SECTION I

DEFINITIONS

Immediate Family Member

You or *your* spouse, the children, brothers, sisters, and parents or step parents of either *you* or *your* spouse; and the spouses of the children, brothers, and sisters of either *you* or *your* spouse.

The wording on page 25 of the policy is:

SECTION III

Other Covered Expenses Include Charges For:

Hospice care.

Covered expenses under this benefit include charges for bereavement counseling services by a licensed clinical social worker, pastoral counselor, or counselor for an *immediate family member* are covered for up to a period of twelve months after the *covered person's* death, up to a maximum benefit of $1,500. …

The wording on page 24 of the policy is:

SECTION III

Other Covered Expenses Include Charges For:

21. *Hospice* care.

Covered expenses under this benefit include charges incurred for the following hospice services:

- part-time intermittent home nursing care by, or under the direction of, a graduate *registered nurse;*
- physical, respiratory or speech therapy;
- medical supplies, including drugs and biologicals and the use of appliances, but only to the extent they would have been covered under the *policy* if the *covered person* had remained in the *hospital;*
- nutrition counseling provided by or under the direction of a registered dietitian as part of the active *hospice* management plan; and,
- counseling services by a licensed clinical social worker, pastoral counselor, or counselor for an *immediate family member,* the primary care giver and individuals with significant personal ties to

- a *covered person* who is terminally ill.

The wording on pages 23 and 24 of the policy is:

Other Covered Expenses Include Charges For:

20. Home health care:

Covered expenses under this benefit include

- Physical, respiratory, occupational, speech therapy;

Specifically excluded from coverage under this benefit are the following:

- Services of a social worker;

Form Number	Form Name
EM 28 18 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage HV+ [Heritage]

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-2-8. American Select Insurance Management Corporation operates in a Program Management role and effective February 12, 2001 began Division of Insurance filings on behalf of Empire Fire and Marine Insurance Company. Empire's policy forms were reviewed by American Select in order to locate any inconsistencies with Colorado insurance law that needed to be addressed with Insurers Administrative Corporation (IAC) that acts as a TPA for Empire. American Select issued Administrative Bulletin #2005-25 on August 5, 2005 and instructed IAC to comply administratively until such time as a Policy Amendment Rider could be prepared for filing in Colorado. Via this Administrative Bulletin IAC was also instructed to review all Colorado insured's previously processed claims related to home health care and/or hospice care and to re-adjudicate in accordance with the Policy's provisions and/or according to the provisions outlined in the attached Addendum – whichever was more favorable to the insured. Attached to the Administrative Bulletin was the "Colorado – Addendum to Administrative Bulletin #2005-25 EMP. The Bulletin advises IAC to refer to the Addendum for the correct benefits and definitions. However during 2004, the period under examination, the policy forms failed to reflect correctly and completely the extent of coverage to be provided for hospice and home health care services

Issue E4: Failure to reflect correct information as to when adopted children become dependents eligible for coverage.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(6.5) Adopted child – dependent coverage

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, regardless of whether adoption of the child is final.

(c)(II) "Placed for adoption" means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. …

The Company's most frequently sold policy in Colorado in 2004 does not appear to reflect correct information as to when adopted children may become dependents eligible for coverage. The policy states adopted children are covered provided the required premium and notice are furnished within 31 days from the date of placement, starting from the earlier of:

- the date the insured acquires physical custody of the child(ren); or,
- the date of birth, if adoption procedures have been approved prior to birth and placement, and *you* are legally obligated to provide coverage for such child(ren).

Colorado insurance law requires that adopted children may become dependents eligible for coverage when a child is placed for adoption regardless of whether adoption is final. "Placed for adoption", is a legal obligation in anticipation of the adoption rather than the point when the child is actually placed in the physical custody of the insured person.

The wording on page 9 of the policy is:

SECTION I

DEFINITIONS

Eligible Dependents

Individuals who are:

- *Your* newly adopted child(ren) and/or children placed with *you* for adoption are covered, provided *we* receive the required *premium* and notice within 31 days from the date of placement, starting from the earlier of:

- the date *you* acquire physical custody of the child(ren; or,

- the date of birth, if adoption procedures have been approved prior to birth and placement, and *you* are legally obligated to provide coverage for such child(ren).

Form Number	Form Name
EM 28 18 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage HV+ [Heritage]

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct information as to when adopted children may become dependents eligible for coverage as required by Colorado insurance law.

Issue E5: Failure to reflect that repairs of prosthetic devices, unless due to misuse or loss, are to be covered.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(14) Prosthetic devices.

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(e) *Repairs* and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added.]

The Company's most frequently sold plan in Colorado in 2004 does not appear to have been in compliance with the requirements of Colorado insurance law during the first eleven (11) months of 2004. The mandatory coverage of repairs of prosthetic devices, unless necessitated by misuse or loss, was not included in the policy until Amendment Rider EM 28 90 (12-04) – SR – CO was added to amend this benefit.

The wording on page 21 of the policy is:

Other Covered Expenses Include Charges For:

6. Artificial limbs, eyes, larynx and orthotic appliances. Replacements are also covered unless necessitated by misuse or loss.

Form Number	Form Name
EM 28 18 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage HV+ [Heritage]
EM 28 90 (12-04) –SR –CO	Amendment Rider

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. Via Administrative Bulletin #2004-26-EMP issued to Insurers Administrative Corporation (IAC) on December 16, 2004 IAC was instructed to review Colorado insured's claims related to prosthetics and re-adjudicate in accordance with the benefit as outlined in Colorado law, if more favorable to the insured. Following the filing of Rider EM 28-90 (12-04) an Addendum to this Bulletin was issued to IAC on February 4, 2005, with instructions to issue the Rider to all in force Colorado insureds in addition to issuing to all new Colorado insureds. It does not appear that further corrective action is needed.

Issue E6: Failure to reflect the availability of an independent external review in grievance procedures.

Section10-16-113.5, C.R.S., Independent external review of benefit denials – legislative declaration – definitions, states:

> (6) All health coverage plan materials dealing with the plan's grievance procedures shall advise covered persons in writing of the availability of an independent external review process, the circumstances under which a covered individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.

Amended Regulation: 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of §10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

> Section 5. Notice and Disclosure of Right to External Review
>
> B. (1) Effective for policies *issued or renewed on or after June 1, 2000*, each carrier shall include a description of the external review procedures *in or attached to all health coverage plan materials dealing with the plan's grievance procedures* including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. [Emphases added.]
>
> (2) The description required under (1) of this Subsection B shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.

The Company's most frequently sold policy in Colorado in 2004 did not include a description of the availability of external review procedures that was required to be included as of June 1, 2000, until a Policy Amendment Rider, with an edition date of December, 2004, was added.

Form Number	Form Name
EM 28 18 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage HV+ [Heritage]
EM 8 90 (12-04)-SR-CO	Amendment Rider

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113.5, C.R.S. and Amended Regulation: 4-2-21. After a review of Colorado insurance law in 2004, the Company filed a Policy Amendment Rider in December, 2004, to disclose the external review procedures and instructed Insurers Administrative Corporation, (IAC) to issue the rider to all in-force Colorado insureds, in addition to issuing to all new Colorado insureds. It does not appear further corrective action is needed.

Issue E7: Failure to use the correct Standard Health Benefit Plan Description Form during 2004.

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states:

(1)(c)(I) The provisions of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:

(D) … The individual carrier shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan in addition to the description form for the individual plan being marketed.

Amended Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

5. Rules

A.4. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:

b) The carrier must provide the applicant with a Colorado Health Plan Description Form for the state's Standard Health Benefit Plans, available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the provisions of Section 10-16-105.2(1)(c)(I)(D), CR.S.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

3. RULES

A. 1. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §§ 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

6. EFFECTIVE DATE

This amended regulation is effective on January 1, 2004.

During 2004, the Company used a 2002 Colorado Standard Health Benefit Plan Description Form rather than the 2004 version for business groups of one applying for individual health benefit plans. This resulted in multiple areas of incorrect information.

Form Number	Form Name
NONE	Colorado Health Plan Description Form 2002 COLORADO STANDARD HEALTH BENEFIT PLANS

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105.2, C.R.S. and Amended Regulations 4-2-19 and 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the correct Colorado Standard Health Benefit Plan Description Form is used for business groups of one applying for individual health benefit plans as required by Colorado insurance law.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS/RESCISSIONS FINDINGS

Issue H1: Failure to provide CoverColorado notice forms in all required instances.

Section 10-8-513, C.R.S., Eligibility for coverage under the program, states:

(1) Except for those individuals who meet the criteria set forth in subsection (2) of this section and except as provided in section 10-8-513.5, any individual who is a resident of this state, unless exempted by subsection (4) of this section, and who has been residing in the United States under the color of law for at least six months, including children who have been placed for adoption, as defined in section 10-16-104 (6.5) or are under the legal guardianship of a resident of Colorado, shall be eligible for coverage under the program, if such individual is able to provide evidence satisfactory to the administering carrier that such individual meets one of the following conditions:

(a) Such individual has applied to a carrier for a health benefit plan and:

(I) *Such application has been rejected or refused because of the health or medical condition of the applicant;* or [Emphasis added]

(II) Such application has been accepted, but at a premium rate exceeding the rate available through the program; or

(III) Such application was accepted with a reduction or exclusion of coverage for a pre-existing medical or health condition for a period exceeding six months.

(b) Such individual has a history of any medical or health condition that is on the presumptive conditions list adopted by the board pursuant to section 10-8-506 (1) (g.5).

(c) Such individual has had a health benefit plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of a premium or premiums. [Emphasis added.]

Section 10-8-521, C.R.S., Notice to residents, states:

If any individual who is a resident of this state applies to a carrier for a health benefit plan and the carrier responds to such application as described in section 10-8-513 (1)

(a), or if any federally eligible individual applies to a carrier for a health benefit plan, *the carrier shall give the individual written notice that the individual may be eligible for coverage under the program, including information about available benefits, exclusions, and premium subsidies, and the name, address, and telephone number of the program.* [Emphasis added.]

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

Section 4. Rules

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible for coverage under the program. The adverse underwriting decisions which require the applicant/insurer to notify the applicant/insured are:

   a. The applicant is rejected for insurance because of the medical condition or history of the applicant; or

   b. The application was accepted, but the premium rate for insurance exceeds the rate available through CoverColorado; or

   c. Coverage will be reduced, limited by a restrictive rider or by the exclusion of coverage for a pre-existing condition for longer than six months.

2. Carriers shall be required to complete the CoverColorado Notice Form for every adverse underwriting determination listed above. Carriers may print the CoverColorado Notice Form on their own stationery but shall use the order, format and content of the CoverColorado Notice Form, as prescribed by the Commissioner of Insurance.

3. The carrier shall attach a copy of the CoverColorado Program Notice Form to the notice of adverse underwriting determination sent to an applicant for insurance. The carrier shall attach a copy of the Notice Form to a copy of the policy and endorsement when it is sent to the insured in the case of an individual being accepted for health insurance coverage but at a premium rate exceeding the rate available through the CoverColorado Program.

The Company provided a population of 138 rescinded policies during 2004. A random sample of fifty (50) files was chosen for review. It does not appear that the Company is in compliance with Colorado law in that none of the fifty (50) files contained the CoverColorado Notice Form for Adverse Underwriting Decisions. Although the files in question had originally been approved for coverage, the Division believes a rescission of coverage based on a retrospective review of eligibility to require the same notice of CoverColorado eligibility as a prospective denial.

POLICIES RESCINDED DURING 2004

Population	Sample Size	Number of Exceptions	Percentage to Sample
138	50	50	100%

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-8-513 and 10-8-521, C.R.S. and Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure that CoverColorado notice forms are provided in all instances required by Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some cases, to pay, deny or settle claims within the required time periods.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

(6) This section shall not prohibit a carrier from retroactively adjusting payment of a claim that is not subject to the provisions of section 10-16-704, if:

(a) The policyholder notifies the carrier of a change in eligibility of an individual; and

(b) The adjustment is made within thirty days after the carrier's receipt of such notification.

Paid and Denied Claims Received Electronically in 2004 Exceeding 30 Days

Data provided by the Company indicated a population of 8,083 paid and denied individual claims received electronically in 2004. The examiners identified 889 claims from this population as taking over thirty (30) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 889 files. Sixteen (16) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
889 *	50	16	32%

*(1% of all paid and denied electronic claims)

Paid and Denied Claims Received Non-Electronically in 2004 Exceeding 45 Days

Data provided by the Company indicated a population of 8,836 paid and denied individual claims received non-electronically in 2004. The examiners identified 1,072 claims from this population as taking over forty-five (45) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 1,072 files. Twenty-six (26) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,072 *	50	26	52%

*(12% of all paid and denied non-electronic claims)

Paid and Denied Claims Received in 2004 Exceeding 90 Days

Data provided by the Company indicated 16,919 paid and denied individual claims received in 2004. The examiners identified 763 claims from this population of 16,919 as taking over ninety (90) days from date of receipt to process. These claims do not appear to have been paid, denied, or settled as required by Colorado insurance law with respect to the ninety (90) day time period.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
763	N/A	763	100%

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J2: Failure to accurately determine the number of days used for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

(1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-106.5(3), (4), and (5).

The Company offers three (3) PPO networks to its insureds in Colorado; Sloans Lake Managed Care, Private HealthCare Systems (PHCS) and First Health. Insureds/providers belonging to the Sloans Lake Managed Care network are instructed to submit claims to Sloans Lake for repricing rather than initially submitting them to Insurers Administrative Corporation (IAC). The claim received date entered in the Company's system is the date that IAC receives the claim from Sloans Lake Managed Care rather than the date the claim was initially received by Sloans Lake. Policyholders belonging to the PHCS and First Health networks are directed to submit their claims directly to IAC. For paper claims, IAC data enters the claims which are then electronically sent to PHCS or First Health and the PPO then returns the claims to IAC electronically. The claim received date entered in the Company's system for these claims is the date that IAC first received the claim from the provider prior to the claim being sent to the PPO for repricing.

All IAC processed claims are adjudicated and finalized online with a nightly batch process that generates the check/explanation of benefits and attaches the paid date to the claim in the system; i.e., a claim finalized on Monday would have Tuesday as the paid date or the next business day in the case of a weekend. After a two-step-control process is conducted internally at IAC, the electronic check and explanation of benefit file is sent to Advance Business Fulfillment (ABF) for printing and mailing. Sometimes the files are picked up by AFB the same day they are released and sometimes the next day depending on the time of the day they are released by IAC. Checks are cut at AFB the same day they are picked up and if flagged are sent out that day, otherwise they are put in the mail the day after they are printed. This can create a difference of up to seven (7) calendar days (if a weekend is involved) from the paid date in the Company's system and the date the check/explanation of benefits is actually put in the mail.

The two (2) procedures described above create additional calendar days beyond what is entered in the Company's system as processing time and results in an inability to accurately track the number of days utilized for processing of claims and to determine in all instances those for which late payment interest and penalties would apply. Carriers cannot avoid their statutory obligations regarding the amount of time allowed for processing claims without interest/penalty being due because an intermediary repricer is involved.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the number of days used for claim processing is determined accurately.

Issue J3: Failure, in some cases, to pay late payment interest and/or penalties.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

The Company has indicated that computation and payment of late payment interest/penalties is not system generated, but is a manual process with late payment interest/penalties being paid when determined to be owed by the claims processor. Empire Fire and Marine Insurance does not process late payment interest/penalties on claims that are re-opened or re-processed with additional benefits being paid after the timely payment period as a result of an initial incorrect payment. The opinion of the Division of Insurance, supported by a recent court decision, is that interest and/or penalties must be paid on adjusted claims if they were originally paid incorrectly. This would include those claims that are

identified by the Company's own audits as well as those adjusted after receipt of a grievance or appeal. However, it would not include additional payments that are based on new or additional information that was not available when the claim was initially paid.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure that, in compliance with Colorado insurance law, late payment interest and/or penalties are paid in all applicable instances.

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